TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Elite Healthcare Fort Worth

Respondent Name
State Office of Risk Management

MFDR Tracking Number
M4-15-3746-01

Carrier's Austin Representative
Box Number 45

MFDR Date Received
July 15, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Carrier has paid this same service before, in full. There is no reason why this date of service should not be paid in full also."

Amount in Dispute: $85.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Upon notification of this dispute the Office performed a review of the medical billing received from Elite Healthcare Fort Worth, in which the Office will maintain no additional reimbursement is owed to the requestor as the initial payment of $28.00 was paid pursuant to the aforementioned rules."

Response Submitted by: State Office of Risk Management

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 7, 2014	99361	$85.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the case management responsibilities by the treating doctor.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment
   - 309 – The charge for this procedure exceeds the fee schedule allowance

- W3 – Additional payment made on appeal/reconsideration
- P13 – Payment reduced or denied based on Workers' compensation jurisdictional regulations or payment policies

Issues

1. Did the requestor support billing the medical conference in accordance with 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to reimbursement?

Findings

1. The respondent reduced reimbursement for the case management services, CPT code 99361, based upon reason code 309 - "The charge for this procedure exceeds the fee schedule allowance."

   28 Texas Administrative Code §134.204(e)(2) states: "Case Management Responsibilities by the Treating Doctor is as follows: Team conferences and telephone calls should be triggered by a documented change in the condition of the injured employee and performed for the purpose of coordination of medical treatment and/or return to work for the injured employee."

   28 Texas Administrative Code §134.204(e)(4) states

   Case management services require the treating doctor to submit documentation that identifies any HCP that contributes to the case management activity. Case management services shall be billed and reimbursed as follows:

   (A) CPT Code 99361.

   (i) Reimbursement to the treating doctor shall be $113. Modifier "W1" shall be added.

   (ii) Reimbursement to the referral HCP shall be $28 when a HCP contributes to the case management activity.

   The requestor billed CPT code 99361-W1; however, the documentation does not support that the treating doctor participated in the case management service.

2. Review of the submitted TEAM CONFERENCE report finds that the requestor listed the participants in the conference; however, the record does not document that it was triggered by a documented change in the condition of the injured employee. As a result, additional reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		August 13, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.